

DATE: _____

PLEASE FILL OUT ALL APPROPRIATE SECTIONS OF FORM.

POLICY #OC-1650-5

EMPLOYEE: LAST NAME	FIRST	MIDDLE INITIAL	EIN#	DATE OF BIRTH / /
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HOME ADDRESS (NUMBER, STREET, CITY, STATE, ZIPCODE)	PHONE NUMBER (HOME) (WORK)
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MARITAL STATUS: _____ SINGLE _____ DIVORCED _____ WIDOWED _____ MARRIED SEX: _____ FEMALE _____ MALE

DATE INJURED / /	HOUR INJURED ____ AM ____ PM	DATE EMPLOYER NOTIFIED / /	LAST WORK DATE AFTER INJURY / /	DATE OF RETURN TO WORK / /
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JOB TITLE (AT TIME OF INJURY)	LENGTH OF TIME AT PRESENT JOB	DEPARTMENT AND SUPERVISOR
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ADDRESS OR LOCATION OF ACCIDENT	CITY	COUNTY	STATE	ZIP CODE
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NATURE OF INJURY (SCRATCH, CUT, BRUISE, ETC.)	FATAL ____ YES ____ NO	PART OF BODY INJURED	SIDE OF BODY INJURED ____ RIGHT ____ BOTH ____ LEFT
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ATTENDING PHYSICIAN AND/OR FACILITY	ADDRESS (NUMBER, STREET, CITY, STATE, ZIP CODE, PHONE NUMBER)
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HOW DID THE ACCIDENT HAPPEN? (STATE ALL DETAILS INCLUDING WHAT YOU WERE DOING, OBJECT MOST CLOSELY CONNECTED WITH ACCIDENT/INJURY.) USE OTHER SIDE IF NEEDED.

WAS A STUDENT INVOLVED ____ YES ____ NO	OTHER PARTY INVOLVED ____ YES ____ NO	IF YES TO EITHER, GIVE NAME AND ADDRESS
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LIST WITNESSES TO ACCIDENT

HOURS SCHEDULED TO WORK DAY OF INJURY (EX. 8:00 AM - 4:00 PM)	ON OVERTIME WHEN INJURED ____ YES ____ NO	NUMBER OF DAYS WORKED PER WEEK
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IF ACCIDENT WAS CAUSED BY NON-STATE EMPLOYEE (GIVE NAME & ADDRESS) OR BY FAULTY EQUIPMENT, UNSAFE PROCEDURES, OR ENVIRONMENTAL CONDITIONS WHICH MAY HAVE CONTRIBUTED TO YOUR ACCIDENT/INJURY EXPLAIN.

WAS PERSONAL PROTECTIVE EQUIPMENT BEING WORN? _____ YES _____ NO

IF YES, WHAT TYPE? (CHECK ONE OR MORE ITEMS BELOW)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> PROTECTIVE CLOTHING | <input type="checkbox"/> FOOT PROTECTION | <input type="checkbox"/> EYE PROTECTION | <input type="checkbox"/> HEAD PROTECTION |
| <input type="checkbox"/> HEARING PROTECTION | <input type="checkbox"/> SEAT BELTS | <input type="checkbox"/> RESPIRATOR | <input type="checkbox"/> BACK SUPPORT BELT |

OTHER (EXPLAIN) _____

IS USE OF PERSONAL PROTECTIVE EQUIPMENT REQUIRED FOR THIS JOB? _____ YES _____ NO

CALL 1-800-837-8583 (In Phoenix: 542-WORK) I have reported injury to this phone number on (Date) _____

EMPLOYEE'S SIGNATURE

DATE SIGNED

Supervisor will not sign unless injury has been reported by phone

SUPERVISOR'S SIGNATURE

DATE SIGNED